Camp Love's Embrace
Camper Health History Form

Camper's Name: (Last) _____(MI)_____(First) _____
Home Address: _____
_____
Date of Birth: _____/_____/_____ Age: _____ Sex: _____

Child's Height: _____ Child's Weight: _____
Parent/Guardian's Phone: Cell ( )_____-_____ Other ( )_____-_____

Health History (check those that apply)

___Attention Deficit Disorder(ADD)
___ADHD
___AIDS
___Asthma
___Allergies
___Convulsions/Seizures
___Constipation/Diarrhea
___Ear Infections
___Diabetes
___Fears
___Fainting
___Heart Disease
___Hearing Impairment
___Hepatitis
___HIV
___Kidney Disease
___Menstrual Cramps
___Motion Sickness
___Nightmares
___Nosebleeds
___Phobias
___Special Dietary Needs
___Sickle Cell Anemia
___Wears Glasses
___Wears Contact Lenses
___Emotional Problems
___Developmentally Delayed
___Other (please specify)

Please explain any information we need to know to care safely for your child: _____
_____
_____

Date of Last Tetanus Shot: _____/_____/_____

Any medications: _____
_____

Are there any activities your child may not be able to participated in while at camp? _____No _____Yes (please explain)

Physician's Name: _____Phone # ( )___-____
Address: _____

To the best of my knowledge, the above information is correct and accurate.
Signature of parent/guardian: _____
Date: _____/_____/_____